EDITOR'S LETTER

It's all happening—at the hospital?

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As of this writing, the health care reform bill has passed the House, but the health care legislative controversy continues. Will we see real health care reform in my lifetime? Who knows? However, I am pleased looking at this issue to see that our profession continues to be focused on improving patient care, both in the hospital and out of it.

The editorial by Michele Klein-Fedyshin, AHIP, sets the tone, with a convincing case for why now more than ever, physicians need ready access to the kind of quality, filtered information that librarians are trained to provide. She points to a puzzling conundrum: pressures are growing to reduce medical errors and increase the use of evidence-based treatment at the same time that requirements to fund professional librarians are declining. Klein-Fedyshin points to some positive developments and envisions a future in which hospitals will be scored on their ''information readiness.''

Also in this issue we are fortunate to publish the papers from an Association of Academic Health Sciences Libraries (AAHSL) symposium on electronic health records held in November in Boston. Two of the papers sound a cautionary note. Kenneth Mandl's keynote address describes structural flaws in the current generation of electronic health records (EHRs) that may prove significant obstacles to their widespread adoption. William Garrity speaks to the need to remember the setting in which EHRs are used: a busy clinician may not have time to consult the evidence even if access to it is easy. However, other papers recount positive experiences with EHRs that may encourage us to move forward in spite of these obstacles. The papers from health sciences librarians at such disparate institutions as the University of Pittsburgh, the University of Washington, the University of Arkansas, and Vanderbilt University recount how these libraries have successfully used their institutions' introduction of the EHR as a means to further their goals.

Finally, Marianne Burke, AHIP, and her colleagues at the University of Vermont describe their attempt to introduce an information prescription protocol into a family medicine practice. In this case study, we learn that it can be done, but that the process is far from easy. Organizations do not change their behavior patterns overnight, and it seems, a clinic is no exception to this common observation.

While not on the subject of patient care, one paper appealed to me particularly. As editor of the *Journal of the Medical Library Association (JMLA)*, I was very interested in the results of the survey recounted by Sally Harvey, AHIP, and Janene Wandersee on the rate of publication of abstracts and papers presented at MLA annual meetings. It seems that we have a lower rate of publication than other biomedical associations. I hope their paper will encourage *JMLA* readers to take the time to write up their papers and posters and contribute them to the ''evidence-base.''

Enjoy the issue.

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